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F 000	INITIAL COMMENTS	F 000	**F. 329 483.45 (d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**	
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

An unannounced Medicare/Medicaid standard survey was conducted 12/6/16 through 12/8/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 56 certified bed facility was 54 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents #1 through #12) and four closed record reviews (Residents #13 through #16).

(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

A review of the Resident #8's care plan and behavior monitoring sheets were confirmed by the Director of Nursing (DON) on 12/8/16, which stated the behavior, the name, the location and physician of the resident.

The nursing staff received refresher training conducted by the Director of Nursing on how to complete behavior monitoring sheets and care plans on 12/16/16.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The Director of Nursing conducted an audit on 12/8/16 of residents who are on Olanzapine/Zyprexa and other anti-psychotics. Any issues that were identified were resolved.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kellie Baker | TITLE: SNA | (X6) DATE: Dec. 21, 2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	Continued From page 1	F 329	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. A behavior reference guide has been developed that indicates what behaviors should be monitored and documented and what follow up actions should be taken. The nursing staff will be educated on the reference guide by the Director of Nursing. (See Appendix A). Education on behavior monitoring on Olanzapine/Zyprexa and other anti-psychotics was completed on 12/16/16. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing, or designee, will audit behavior monitor sheet and electronic Treatment Administration Record (eTAR) of residents with Olanzapine/Zyprexa and other anti-psychotics for compliance with behavior monitoring to confirm-documentation includes residents name, location, physician and specific behavior . If issues are identified during the audit process, then coaching, and corrective action will occur.	

by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a resident was free from unnecessary drugs for one resident of 16 residents in the survey sample, Resident # 8.

The facility staff failed to monitor behaviors for the use of Olanzapine (1), an antipsychotic medication for Resident # 8.

The findings include:

Resident # 8 was admitted to the facility on 6/3/09 with diagnoses that included but were not limited to: depressive disorder, gastroesophageal reflux disease (2), Parkinson's disease (3), atrial fibrillation (4), paranoid schizophrenia (5), heart disease, chronic kidney disease and dementia (6).

Resident # 8's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 10/11/16 coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, 2 being severely impaired of cognition for daily decision making. Resident # 8 was coded as requiring extensive assistance of one staff member for activities of daily living. A review of Section E "Behaviors" coded Resident # 8 as not exhibiting any behaviors.

The POS (Physician's Order Sheet) dated December 1, 2016 for Resident # 8 documented,
· "Olanzapine 2.5 MG (milligram) Tablet. Give 1.25 mg orally at bedtime for schizophrenia. Order Date 0913/2015."
· "Monitor behavior episodes and attempt to

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F 329	Continued From page 2 determine underlying cause and side effects of antipsych (antipsychotic) meds (medications). Consider location, time of day, persons involved and situations. Document nurse's notes for noted behaviors and interventions as needed." The physician's progress notes for Resident # 8 dated 9/1/16, 10/14 16 documented, "Schizophrenia - Zyprexa (Olanzapine (7)"). The physician progress note dated 11/4/16 documented, "Schizophrenia -Olanzapine." The eMAR (electronic medication administration record) dated September 1, 2016 through December 6, 2016 for Resident # 8 documented, "Olanzapine 2.5 MG (milligram) Tablet. Give 1.25 mg orally at bedtime for schizophrenia. Start Date 09/13/2015." Further review of the eMAR revealed Resident # 8 received an Olanzapine tablet at 8:00 p.m. every day from 9/1/16 through 12/6/16. The eTARs (electronic Treatment Administration Record) dated October 1, 2016 through December 6, 2016 for Resident # 8 documented, "Monitor behavior episodes and attempt to determine underlying cause and side effects of antipsych (antipsychotic) meds (medications). Consider location, time of day, persons involved and situations. Document nurse's notes for noted behaviors and interventions as needed every shift related to Paranoid Schizophrenia. Start Date: 1/13/2016." The eTARs dated 9/1/16 through 12/6/16 revealed that Resident # 8 did not have any behaviors. Further review of the eTARs failed to document Resident # 8's targeted behaviors for the use of Olanzapine. Resident # 8's care plan dated 12/15/2014 was	F 329	The Director of Nursing, or designee, will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. 5. Include dates when the corrective action will be completed. All corrective actions completed by 1/6/17.	

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F 329	Continued From page 3	F 329		

reviewed. Under "Focus" it documented, "The resident has a potential of behavior problem r/t (related to): delusions or hallucinations r/t (related to) schizophrenia and psychoactive medications." Under "Interventions" it documented, "Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document as needed. Date initiated 12/15/2014." Further review of the care plan failed to evidence targeted behaviors for the administration of Zyprexa to Resident # 8.

The facility's "Progress Notes" dated 9/1/16 through 12/6/16 for Resident # 8 failed to evidence documentation and monitoring of Resident # 8's behaviors.

On 12/7/16 at 12:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked what behaviors were being monitored for Resident # 8, LPN # 2 stated, "Behaviors that are out of the ordinary." When asked to clarify "Out of the ordinary." LPN # 2 was unable to provide specific targeted behaviors exhibited by Resident # 8.

On 12/7/16 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked what behaviors were being monitored for Resident # 8, ASM # 2 stated, "The list of behaviors is listed on the med (medication) cart." An observation of the nurse's med cart was then conducted with ASM # 2. Tapped to the top of the med cart was a form entitled "Behavior Monthly Flow Sheet, December 2016." The behavior flow sheet documented behaviors and "Behavior Codes" numbering one to 38; "Intervention

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Codes" numbering one to 11 and "Outcome Codes" identified by "I - Improved, S - Same and W - Worsened." The behavior flow sheet also documented, "Name, Location, Physician." The behavior flow sheet failed to evidence the name of the resident, location, name of the physician, specific behaviors, intervention codes and outcome codes. When asked which behaviors were being monitored for Resident # 8, ASM # 2 stated, "Any of these behaviors" referring to the list of 38 behaviors listed on the behaviors flow sheet. ASM # 2 was unable to identify the specific behaviors that were be monitored for Resident # 8.

On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of these finding.

References:

(1) Olanzapine is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) in adults and teenagers 13 years of age and older. Olanzapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601213.html.

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(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(5) The paranoid type of schizophrenia is dominated by delusions and/or auditory hallucinations. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/17236.htm.

(6) Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(7) Zyprexa (olanzapine) is one of a group of medications called atypical antipsychotics. Zyprexa is used to control delusional thinking, apathy <http://www.goodtherapy.org/blog/psychpedia/apathy>, strong emotions, and other symptoms that may accompany schizophrenia experienced by adults and teenagers over the age of 13. This information was obtained from the website:

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F 329	Continued From page 6	F 329	**F. 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD LINENS**	
	http://www.goodtherapy.org/drugs/zyprexa-olanzapine.html.			
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
	(a) Infection prevention and control program.		If information was not supplied by the lab or no culture was performed, it is so stated on the infection control log. We reviewed and completed the infection control logs from Jan. 2016- Nov. 2016.	
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:		2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	
	(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);		A comprehensive audit was performed by the Director of Nursing on 12/9/16 of infection control logs and "N/As" were added. Any issues identified for incomplete documentation were resolved.	
	(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:		3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	
	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			
	(ii) When and to whom possible incidents of communicable disease or infections should be reported;			
	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			
	(iv) When and how isolation should be used for a			

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F 441	Continued From page 7 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to maintain an effective infection control program as evidenced by incomplete monthly infection logs from January 2016 through November 2016. The facility monthly infection logs from January	F 441	The nursing staff received refresher training conducted by the Director of Nursing on how to thoroughly review lab reports and the process for adding N/A or the specific organism to the infection control log when applicable). Refresher training for infection control log was completed on 12/16/16. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing, or designee, will audit the infection control logs on a weekly basis to confirm there is documentation that reflects either N/A or the specific organism. If issues are identified during the audit process, then coaching and corrective action will occur. The Director of Nursing or designee will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period.	

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F 441	Continued From page 8	F 441	The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.	

2016 through November 2016 were incomplete and failed to document the organisms identified for infection cultures that were obtained.

The findings include:

A review of the monthly facility infection logs from January 2016 through November 2016 was conducted. The following was documented:

January 2016: 15 infections were documented. Four documented that cultures were completed but only three documented the organism that was identified.
February 2016: Ten infections were documented. Four documented that cultures were completed but only two documented the organism that was identified.
April 2016: 18 infections were documented. Six documented that cultures were completed but only four documented the organism identified.
May 2016: 12 infections were documented. Three documented that cultures were completed but only two documented the organism identified.
July 2016: Ten infections were documented. Three documented that cultures were completed but only one documented the organism identified.
August 2016: 17 infections were documented. Three documented that cultures were completed but only two documented the organism identified.
September 2016: 15 infections were documented. Seven documented that cultures were completed but only five documented the organism identified.
November 2016: 18 infections were documented. Five documented that cultures were completed but only three documented the organism identified.

5. Include dates when the corrective action will be completed.

All corrective actions completed by 1/6/17.

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During the end of day interview on 12/7/16 at 5:40 P.M. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, the concern of the lacking information on the Infection Control Logs was reviewed.

During an interview on 12/8/16 at 8:45 a.m. with ASM # 2 the missing laboratory results identifying the "organism" on the infection control logs was again reviewed. ASM # 2 stated that they never give antibiotics unless they have the culture results. ASM # 2 stated that she does not complete the logs but stated that she is responsible for overseeing the program. When asked the purpose of tracking infections in the building, ASM #2 stated that the logs are used to track and trend infections in the building and to determine what staff education is needed if they see a rise in certain types of infections.

Review of the facility policy, "Infection Prevention & Control Program" documented, "It is the community's policy to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with CDC. The Center for Disease Control (CDC) www.cdc.gov <http://www.cdc.gov> may be used to support the Infection Control Program." Under " Procedure: 1. The Director of Nursing oversees the overall Infection Control Program...6. The Infection Control Nurse/designee collects and analyses surveillance data, and make recommendations to Quality Assurance Performance Improvement Committee....8. The Director of Nursing/Infection Control Nurse: a. Monitors the effectiveness of the Infection Control

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F 441 SS=D	Continued From page 10 Program b. Evaluates infection control compliance and staff practices..." No further information was provided prior to exit. F 465 483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure chemicals were locked in a cabinet for one of six facility resident bathrooms, (Ash Neighborhood unit resident bathroom). One six ounce aerosol can of air freshener available for use was found in an unlocked cabinet in the Ash Neighborhood unit resident bathroom. The findings include: On 12/8/16 at approximately 10:20 a.m., an observation was made of the facility's resident bathroom on the "Ash Neighborhood" unit with OSM (other staff member) # 4, director of engineering. Upon opening the unlocked cabinet	F 441	**F. 465 483.90 (h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT** F 465 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. At the time of survey, the aerosol can was removed and placed in the dumpster. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The six public guest and resident bathrooms were inspected on 12/8/16 by the Director of Nursing and the Director of Housekeeping and no other aerosol cans or chemicals were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Staff received refresher training conducted by the Director of Nursing, or designee, on 12/16/16 regarding the importance and process for securing chemicals, how to address families that wish to bring in air freshener or cleaning	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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under the bathroom sink revealed a small basket containing paper towels and a six ounce aerosol can of air freshener. OSM # 4 stated, "It shouldn't be here. This product is not provided by our vendor, it must have been brought in by someone." ASM (administrative staff member) # 2, director of nursing, was then asked to come to the resident bathroom on the "Ash Neighborhood" unit. After observing the basket with the six ounce aerosol can of air freshener ASM # 2 stated, "It shouldn't be here. The bathroom should have been checked by housekeeping and nursing." After examining the aerosol can OSM # 4 stated, "The can is about half full." OSM # 4 then removed the aerosol can from the bathroom.

The label on the aerosol can of air freshener found in the facility's resident bathroom on the Ash Neighborhood documented, "Caution: Eye irritant. May be harmful if directly inhaled. May cause allergic reaction in some individuals."

On 12/8/16 at approximately 11:15 a.m. an interview was conducted with OSM # 3, director of housekeeping, regarding the aerosol can of air freshener that was found in the facility's resident bathroom on the Ash Neighborhood unit. OSM # 3 stated that the air freshener was not the type used by the facility and it must have been brought in by someone. When asked if the housekeepers check the bathrooms for items that don't belong there OSM # 3 stated, "They're supposed to."

On 12/8/16 at approximately 11:20 a.m. an interview was conducted with ASM # 2 regarding the aerosol can of air freshener that was found in the facility's resident bathroom on the Ash Neighborhood unit. ASM # 2 stated, "We let the families and residents know not to bring in

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products, and how to report and resolve a lack of compliance.

In addition, a letter was sent to residents and families on 12/16/16 reminding them of the protocols regarding chemical and cleaning product usage, storage, and the necessity of the community using commercial products that are designed for a health care setting.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Administrator, or designee, will inspect the six public guest and resident bathrooms on a weekly basis. If issues are identified during the audit process, then coaching, and corrective action will occur.

The Administrator or designee will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months.

At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495197	A. BUILDING _____ B. WING _____	C 12/08/2016

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F 465	Continued From page 12 aerosol cans. Nursing and housekeeping should be checking the bathrooms on a daily basis for aerosols." During the days of the survey, resident were not observed entering the resident bathroom on the "Ash Neighborhood" unit. The facility policy "Chemical Safety: Resident Risk Reduction" documented, "Communities must take the appropriate precautions to minimize resident's risk of injury from chemicals and other hazardous materials through a combination of diligent monitoring, proper chemical-selection, safe dispensing systems, proper usage and restricted access to authorized team members in a manner that is consistent with (Name of Facility's) Principles of Service." On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of these finding. No further information was provided prior to exit.	F 465	The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. 5. Include dates when the corrective action will be completed. All corrective actions completed by 1/6/17.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514		

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F 514	Continued From page 13	F 514	**F. 514 483.70(i)(1)(5) RESIDENT RECORDS – COMPLETE/ACCURATE/ACCESSIBLE**	

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 16 residents in the survey sample, Resident # 7.

The facility staff failed to accurately document Resident # 7's allergies on the current POS (physician's order sheet).

The findings include:

Resident # 7 was admitted to the facility on 12/10/13 and a readmission of 12/10/15 with diagnoses that included but were not limited to:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

At the time of survey, the Director of Nursing updated the Physician Order Sheet of resident # 7 to correctly indicate the appropriate allergy and informed the pharmacy of the error in the system, so that the POS could be updated.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 12/8/16, the Director of Nursing conducted an audit of residents medical records to confirm that identified allergies were reflected on the Physician Order Sheet. No issues were identified.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 12/16/16, The Director of Nursing conducted refresher training for nurses on Physician Order Sheets and medical records mandating the

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macular degeneration (1), benign prostatic hyperplasia (2), hypertension (3), dysphagia (4), and pain.

Resident # 7's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 9/13/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living.

Review of Resident # 7's clinical record revealed a sticker on the inside cover of the clinical record. The sticker documented, "Allergies: Percocet (5)."

The POS (physician's order sheet) for Resident # 7 dated December 2, 2016 documented, "Allergies: No Known Allergies."

On 12/7/16 at 8:35 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After being asked to review Resident # 7's clinical record ASM # 2 was asked to identify Resident # 7's allergies. ASM # 2 identified the sticker on the inside of the clinical record that documented, "Allergies: Percocet," and the current physician's order dated December 2, 2016 that documented, "Allergies: "No Known Allergies." ASM # 2 stated, "I'll check the system to clarify it." After checking the electronic health record ASM # 2 stated, "The physician's order sheet is not correct. The pharmacy didn't pick it up. I'm doing a clarification now."

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necessity of resident allergies. The Director of Nursing, or designee will monitor the accuracy of allergies on Physician Order Sheets and medical records on a monthly basis.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing, or designee, will audit accuracy of Physician Order Sheets and medical records for appropriate allergies for new admissions and on a monthly basis.

If issues are identified during the audit process, then coaching, and corrective action will occur.

The Director of Nursing, or designee, will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months.

At the conclusion of the three months, the Quality Assurance Performance Improvement committee will re-evaluate and initiate any necessary action or extend the review period.

The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of

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F 514	Continued From page 15	F 514	Correction and addressing and resolving variances that may occur. 5. Include dates when the corrective action will be completed. All corrective actions completed by 1/6/17.	

On 12/7/16 at 9:30 a.m. ASM # 2 provided this surveyor with a copy of the physician's order sheet (POS) for Resident # 7 dated 12/7/2016. The POS documented, "Allergies: Oxycodone."

On 12/7/16 at 11:20 a.m. an interview was conducted with ASM # 4, physician. When asked about the potential side effects if Resident # 7 was administered Percocet, ASM # 4 stated, "There could be drowsiness, loss of appetite and constipation."

On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of these finding.

No further information was provided prior to exit.

Reference:

(1) A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.html.

(2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.